To: Intermediate Unit I Educational Support Professional

From: Michael Llewellyn, Business Manager

Date: April 5, 2025

Re: Election of health insurance for the 2025-2026 school year

You will need to choose your health insurance coverage for the 2025-2026 school year from the options noted below. Attached are explanations of the options to review when choosing the health benefits coverage. This year American Fidelity will be completing the open enrollment sign off. The link to schedule with American Fidelity is https://enroll.americanfidelity.com/4CB62FF2. **Your enrollment must be received in the Business Office by 3:30 PM Friday, May 9th in order to receive coverage for the next fiscal year, July 1, 2025 to June 30, 2026. American Fidelity will be collecting the forms and signatures during open enrollment meetings.** The enrollment with American Fidelity will include medical, dental, vision, and Payment in Lieu of Insurance. In addition, you can purchase voluntary benefits if you would like. You can schedule your meeting in person or virtually. Please click the link to schedule your appointment - https://enroll.americanfidelity.com/4CB62FF2.

Option 1 Consortium EPO Plan:

If you choose the Consortium EPO Plan, the Board will provide coverage for the individual coverage. If you elect to expand coverage to husband and wife, parent and child, parent and children, or family contract you are able to make that selection. You shall pay the co-premium in accordance with your negotiated contract in effect for July 1, 2025, which is 6.5% of the monthly premium for individual coverage. If you elect any additional coverage, you will pay the co-premium plus the difference in cost for the additional coverage. **As a note, under the Allegheny County School Health Consortium, you will have a separate prescription card. I am attaching the insurance coverage changes from Allegheny County School Health Insurance Consortium.**

Option 2 Consortium PPO Plan:

If you choose to buy up to the Consortium PPO Plan, the Board will provide coverage for the individual. If you elect to expand coverage to husband and wife, parent and child, parent and children, or family contract you are able to make that selection. You shall pay the co-premium in accordance with your negotiated contract (as listed above) in effect for July 1, 2025, plus the cost of the additional coverage. In addition, you will be responsible for the difference in monthly premiums. **As a note, under the Allegheny County School Health Consortium, you will have a separate prescription card**.

		Individual	Parent/Child	Parent/Children	Emp/Spouse	Family
A	**Option 1: EPO Monthly Premium**	$872.04	$1,956.01	$2,151.58	$2,368.98	$2,463.24
B	**EPO Monthly Employee Co-Premium at 6.5% of Premium**	$56.68	$1,140.65	$1,336.22	$1,553.62	$1,647.88
C	**Option 2: PPO Monthly Premium**	$933.48	$2,092.89	$2,302.20	$2,535.91	$2,636.62
D	**Additional Estimated Monthly Employee Cost for PPO**	$61.44	$136.88	$150.62	$166.93	$173.38
E	**Total Monthly Estimated Employee Cost to Buy-Up to PPO (B+D)**	$118.12	$1,277.53	$1,486.84	$1,720.55	$1,821.26

Please complete your enrollment by Friday, May 9th. **This enrollment must be completed by 3:30 PM May 9th** to ensure that coverage will be provided. American Fidelity will conduct the healthcare enrollment and Section 125 enrollment and employee sign off in accordance with IRS regulations during the same meeting.

Please indicate your choices below; fill out the remainder of this page and sign the bottom of the page. **This form must be returned to the Business Office by 3:30 PM May 9th**. We must do this to ensure that coverage will be provided.

Check "Option" in column 3 if you decline the health insurance coverage. If you want the district to provide for Dental & Vision, please make sure to check the respective coverage.

Health Coverage Provided:		**Dental Coverage**		**Buy Out in Lieu of Benefits**:	
EPO	❑	Basic Dental	❑	Consortium EPO	❑
PPO	❑	**Vision Coverage**		Dental	❑
		Vision	❑	Vision	❑

MARITAL STATUS _____ I QUALIFY FOR THE FOLLOWING COVERAGE:

❑ Individual ❑ Husband/Wife ❑ Parent + Child ❑ Parent + Children ❑ Family

If you qualify for husband/wife or family coverage, for example, but elect individual coverage, please indicate your preference for individual coverage.

❑ I qualify for _____coverage but elect individual coverage. My spouse or family member has coverage through another plan.

If the status of a dependent has changed, please check or circle the correct coverage:

Dependent Name: _____

Remove dependent Dental/Health/Vision because of ❑ legal separation; ❑ divorce; ❑ death; ❑ military service; or

child has ❑ married; ❑ become employed; ❑ reached 26th birthday; ❑ other_____

Indicate below those family members who qualify to be covered by your health insurance. Include spouses and unmarried children less than 26 years of age.

Name of Spouse/Dependent	**Social Security #**	**Age**	**Birthdate**	**Relationship (**Include dependents Age 19-26)

Print Name: _____ Employee Signature _____ Date _____